Trafford Local Care Organisation

Leading local care, improving lives in Trafford with you

CLIENT REFERRAL FORM

Title:
Name:
Address:

Office use only
ID No:

Referral Received :
S&P ☐ **B** ☐

Postcode:

D of B :
Sex : M ☐ **F** ☐
Ethnicity :

Other family members being seen Y / N
Details :

Phone: Home:

Work/Mobile:

Can messages be left: **YES** ☐ **NO** ☐

Email Address:

NHS Number (if known):

GP:
Address:

GP Phone:

Referred by: Self ☐

Referral Date:

Other ☐ Name & Relationship to client………………………………………………………………..

Health Professional ☐ Name ……………………………………………
Professional role / designation……………………………………………..

Address (if referred by Professional)

Phone:

Method of Referral: Phone ☐ Face to Face ☐
Fax ☐ Letter ☐ (Date on letter……………………………….)

Does the client understand and accept the referral? Yes ☐ No ☐

Reason for referral, including presenting issues:

Previous counselling/psychiatric history:

Current Medication:

Please send to: Wellbeing Counselling Service
Macmillan Wellbeing Centre, Moorside Road, Davyhulme M41 5SN